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HUMAN HORN (CORNU CUTANEUM OF ROKITANSKY).

[Read before the Boston Society for Medical Improvement, and communicated for the Boston Medical and Surgical Journal.]

BY SILAS DURKEE, M.D.

ON the 24th of December, 1864, Dr. Hoffendahl, of this city, gave me a polite invitation to see a patient of his who has had a horny excrescence growing on the right forehead for the past six years. The patient is a female, 92 years of age, and resides in Charlestown. She still retains her mental faculties quite well, and was able to answer with apparent accuracy my inquiries relative to her case. She stated, in substance, that the horny growth commenced as a small, hard pimple, rising just above the adjacent skin, and situated about an inch above the outer portion of the eyebrow. For three or four years it increased very gradually. It has never occasioned much inconvenience, unless when accidentally struck, or brought in contact with the clothing. During the last twelve or fifteen months previously to my seeing it, it grew more rapidly than it had done before.

The old lady was gratified that we had called to see "her horn," of which she was quite proud, and at once removed the linen rag that covered it. It had a broad base, which measured four inches and seven eighths in circumference. The surrounding integument was a little inflamed, and formed a delicate red circle about two lines wide. The excrescence was of a conical shape, and was inclined downwards, like a ram's horn or the beak of a bird. Its length along the upper curve measured three inches and seven eighths. It was easily movable, and was evidently not attached to bone. The inferior border occupied the integument just over the outer portion of the superciliary ridge, and encroached slightly on the eyebrow. For the first half inch from its origin it was soft and pulpy to the touch, consisting, as it did, of an accumulation of concreted sebaceous matter confined in the dilated sac of a sebaceous duct. It bulged out, and served as a sort of cushion or shoulder for the portion above to rest upon. The latter was hard and unyielding under pressure. It was rough, and longitudinally ribbed and marked by several irregular depressions.

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There was one groove or furrow commencing half an inch from the base and running along the upper surface, extended two inches towards the apex, as if an attempt had been made to divide it into two nearly equal parts. It had apparently a fibrous structure, the arrangement of its cells being parallel to its length. It tapered to a blunt point, which was bent downward and backward until it came in contact with the inferior portion one inch from its base. No attempt had ever been made for its removal, because the woman persistently objected.

There were several other horny formations, varying in size, upon the face and skin. None of them had attained more than a line or two above the adjacent skin. The dimensions and relative position of the two largest are represented in the accompanying engraving from a plaster cast which was taken a few days after I saw the case. From long exposure to air and floating dust, they were of a dull brown or nearly black color, while the principal specimen, above described, was of a dirty white. In the early part of May, 1865, the inflammation began to increase, and a poultice composed of the powdered root of *hydrastis Canadensis* was applied for several weeks, when the hard, dense portion of the horny texture was cast off. Dr. Hoffendahl informs me that the poultices changed the surface so as to impart a greenish tint to the color, and now in its dry state the green is still visible. Subsequently, the impacted sebaceous matter enlarged the aperture of the soft follicular sac which constituted the base of the indurated mass—a still higher inflammation set in, followed by ulceration, which spread rapidly in all directions; the walls of the hypertrophied sac were destroyed; the diseased action assumed in all respects an unfavorable character, and the malady is now (December 13th, 1865) doubtless an epithelial cancer, which covers a large portion of the forehead and yields an exceedingly offensive discharge. The poor woman has failed very much during the past few months. She is deaf and blind and helpless, and is a most pitiable object to behold.

She has had two children, both of whom are living—one 75 years old, the other 70, and thus far both are exempt from the malformation in question. Her grandmother had a cutaneous horn in the same locality with the one in the present instance. I was informed that it terminated in a cancer—the woman living, however, to the extreme age of 96 years.

The constituent elements of cornified textures on the human subject have frequently been ascertained by chemical analysis. They consist chiefly of albumen, a small quantity of mucus, phosphorus, chloride of sodium and a trace of lactate of soda.



Professor Wilson has collected ninety cases, of which forty-four were females and thirty-three males; of the remainder the sex is not mentioned. Of this number, forty-eight were seated on the head, four on the face, four on the nose, eleven on the thigh, three on the leg and foot, six on the back, five on the glans penis, and nine on the trunk of the body.

The most remarkable case on record is that of a Mexican porter, who had a horn situated on the upper and lateral part of the head, fourteen inches in circumference around its shaft, and divided above that point into three branches.

By the early application of alkaline or common water dressings, these singular alien growths are easily detached from the inner surface of the follicular tumors from which they spring; and by the use of caustics to the sac the further abnormal cell-development can usually be arrested.

ON THE PRACTICAL USES OF THE LARYNGOSCOPE AND THE RHINOSCOPE.

By EPHRAIM CUTTER, M.D.

[Communicated for the Boston Medical and Surgical Journal.]

IN DIAGNOSIS. *Laryngoscopy.*—Laryngoscopic diagnosis is positive and negative. Negative laryngoscopic diagnosis occurs where the symptoms point to the larynx and no appreciable lesion appears to explain them. Negative evidence, when true, is quite as useful as positive, and sometimes more so. It is valuable by way of exclusion. It directs attention to other than topical causes of disease. It decides questions of interference, whether medicinal or surgical. It is considerably important to know when to treat and when *not* to treat. Physicians should not labor to accomplish unattainable objects. It wastes their time and the patient's resources, and leads to an unpleasant termination of the affair in an *opprobrium medici*.

CASE I.—*A middle-aged Man with Aphony, caused by no discoverable Lesion in the Throat or Larynx.*—In September, 1865, Dr. Henry I. Bowditch, of Boston, kindly submitted to the writer a stout, dark-complexioned man of 45 years, complaining of aphony of several months' duration. Unassisted physical exploration revealed no lesion sufficient to explain the difficulty.

On inspection by laryngoscopy, the epiglottis appeared normal in its body, wings, cushion, tip and edges. The arytenoid cartilages and their connecting band were natural. The color, conformation and physical appearances of the walls of the larynx, the vocal cords, and the mucous membrane of the trachea, were also normal. (The idea of normal was gained by previous inspection of healthy larynges.) A negative diagnosis was given, and the attending physician was directed to other invisible causes. Pressure upon the recurrent la-

ryngeal nerve by an aneurism of the arch of the aorta was suggested.

CASE II.—Supposed Foreign Body in the Larynx of a Child four Years of age; Negative Diagnosis.—November, 1865. A patient of Dr. W. F. Stevens, of Stoneham, Mass., a boy of four years, had been sick several weeks with severe cold, attended with physical signs of bronchitis, with an unusual rattling and irritation in the throat, and with cough. The symptoms were variable, and yet so persistent and unyielding that the question was raised by the attending physician and parents whether there might not possibly be a foreign body furtively lodged by the child in the larynx. Phonation was perfect at the time of the examination.

By laryngoscopy, the epiglottis and vocal cords, with the glottis, were well made out, and no signs of any foreign body were discovered. The issue has confirmed this diagnosis, which, although *negative*, in this case was far more gratifying than a *positive* one would have been.

CASE III.—Occasional Choking, Hoarseness and Distress in Throat, associated with a Nervous Temperament; no Physical Lesion.—August, 1865. Mrs. H. C., Winchester, Mass., head of a family, thin, pale, nervous, aged about 55 years. Complained of severe spells of choking, hoarseness and distress, which had affected her for some years at intervals. The paroxysms lasted for several minutes, seized her at any time of the day, and were more frequent when debilitated by overwork, sickness or unusual fatigue. She has had several severe attacks of pneumonia during her life, and also has enlargement, with functional disturbance of the heart.

Careful and repeated successful laryngoscopic examinations failed to disclose any solution of continuity, or any change in structure, color, size and consistency of the parts about the pharynx, larynx or trachea.

Diagnosis negative in regard to physical lesion, but positive in relation to a disturbance of the nervous forces—to be relieved by supporting treatment.

In positive diagnosis by the laryngoscope, some malformation, congenital or acquired, or some lesion of structure, either organic or functional, is brought distinctly to view.

CASE IV.—About one year ago, Mr. W. W. Baker, of Thetford, Vt., came under my observation from the Massachusetts General Hospital, sent by Dr. Bowditch. He was a farmer, of medium stature, light complexion, and feeble appearance. He was breathing through a tracheotomy tube, which had been inserted during fearful paroxysms of dyspnea by Dr. Crosby, of Hanover, N. H., about nine months before. He was aphonic. Breathed with some difficulty, and with some noisy rattling. Deglutition was somewhat difficult. His nights were sleepless. He had a great deal of pain in the throat. His troubles had existed for about three years. His general health had suffered, and he had become considerably reduced. At the first sit-

ting, the laryngoscope revealed a quadrilateral tumor making a space between the orifice of the œsophagus and the laryngeal opening, involving the anterior and upper half of the gullet and the adjacent posterior part of the larynx, between both arytenoid cartilages. This swelling was about five eighths of an inch square, measured by the eye, smooth, white, glistening. The epiglottis was much folded naturally, and pushed forward from the posterior pharyngeal wall. The whole larynx was much smaller than usual. The antero-posterior diameter was diminished one half, taking an adult man's larynx for a standard. The vocal cords were a milk-and-water white, thinned, atrophied, and destitute of the normal white pearly sheen.

Diagnosis—from the pain and the physical appearances—cancer of the œsophagus, involving the larynx, structurally and mechanically.

Treatment.—All treatment declined; considered a case beyond human aid.

Remarks.—The question may be asked, as you could not cure him, of what use was the laryngoscope in this case? The answer is, that the truth was clearly ascertained. There is a satisfaction, melancholy to be sure, in an accurate diagnosis of a malignant disease. Moreover, without this special investigation, no one could have known the exact state of the disease. The patient was but just alive at last accounts. It should be added, that the above diagnosis was afterwards demonstrated to Dr. Bowditch, who concurred in it from actual inspection.

CASE V.—Aphonia, caused by a pedunculated Cauliflower Excrecence on the Right Vocal Cord.—November, 1865. A boy, 6 years of age. Seen in the office of Drs. Douglass and Richards, the successors of Dr. Horace Green, of New York. Had been aphonic for a year, I think, and had been for six weeks under a course of throat training or education, by Dr. Douglass. The laryngoscope in the writer's hands confirmed the previous laryngoscopic diagnosis of Dr. Douglass, by revealing a polypus seated on the middle of the upper surface of the right vocal cord, of the size of a small five-grain pill, shape globular, its free surface irregularly and minutely bossed, its attached surface connected with a short stalk seated as above. Its color was of a palish white.

CASE VI.—Aphonia, caused by a Growth springing from the upper posterior part of the Larynx, near the left Arytenoid Cartilage.—Seen at the same time and place as Case V. A stout, middle-aged mechanic, aphonic. The laryngoscope revealed a fleshy excrecence, projecting like a knob, one quarter of an inch in diameter and in protuberance. Its free extremity was irregularly broken up into minute projections. Its color was a pale red.

CASE VII.—A T-shaped Polypus on the Left True Vocal Cord, of enormous size and curiously perforated.—Philadelphia Hospital, Blockley, November, 1865. A United States soldier, 50 years of age, born

in Charlestown, Mass., in 1850 fell and received the force of his fall upon the larynx and windpipe. Since that time he has been aphonic. He had been in some army hospital at Washington, and at the close of the war had somehow gravitated into the above locality. The diagnosis coming with him was "rupture of the vocal cords," said to have been pronounced by a board of army surgeons. Laryngoscopy immediately revealed to the writer, and also to Dr. Ludlow and his assistants, the existence of a T-shaped polypus starting from the middle of the upper surface of the left lower thyro-arytenoid band, projecting inwards, where it was joined by another oblong portion exactly at right angles, forming a shape like the letter T. The part corresponding to the bar of the T was apparently of the size of the last joint of the little finger, and occupied all the space in the larynx antero-posteriorly, leaving a considerable margin for both sides. Very curiously, on the thyroid end of the "bar," was a complete perforation vertically, so large that I saw distinctly through it. There were striations parallel to the length of each of the parts of the polypus. Its color was red, like a healthy mucous membrane. A second examination, a few days after, confirmed the first.

CASE VIII.—*Esophagoscopy; Disease of the Oesophagus, involving the Larynx.*—Mr. O. C., coal and lumber dealer in Boston, residing in Dedham, 60 years of age, a stout, large-framed, powerful man, came under my observation May 15th, 1865. Complained of dysphagia, dyspnoea, aphonia, rattling in throat, great pain in throat, and particularly at both joints of the lower jaw. These troubles had lasted for about two years. His general health had suffered. Besides, he was subject to debilitating attacks of diarrhoea every summer. He was able to take only liquid food, and a good portion of that was rejected from the throat. An audible sound of rattling in the throat was present most of the time. There was considerable expectoration, of a varied character. Sometimes it was a curious, pale purple, sometimes dark colored, sometimes it was white, aerated and viscid. It had no perceptible unpleasant odor. The lungs and heart were normal. Sometimes there was great pain in the bowels, particularly during the attacks of diarrhoea. No trouble with urinary organs, and *no syphilis* whatever. This case was seen in consultation with Dr. Bowditch, and courteously placed in my hands for diagnosis and treatment.

On inspection with the laryngoscope, what was thought to be the vocal cords was seen with some ulcerated surfaces around. There were white objects at either side of an open cavity at the root of the tongue. This was the first observation. On further careful study, the opinion was altered from the following reasons:—1st, the epiglottis did not preside over this cavity. It was found far to the front, pressed toward the right, very much folded on itself, and somewhat ulcerated on its edges. 2d. Sometimes there was a collection of mucus in this cavity, which was stationary, and did not move with or

impede the movements of the breath. 3d. The posterior wall of the pharynx was found continuous with the cavity. Oesophagoscopy had been thus performed. The white objects were ash-colored debris covering the ulcerations in the oesophagus. The edges of the gullet were immensely thickened, everted, fissured, looking very much like piles everted about an anus. The oesophageal tumor was continuous with the left arytenoid cartilage, which was enormously swollen at times and covered with thickened, sometimes oedematous mucous membrane. The diagnosis was positively malignant disease of the oesophagus involving the larynx.

CASE IX.—*Aphonia, with severe Cough, shown to be dependent upon an Epiglottis bent to a right angle, and fissured by Ulceration almost to its Base, and upon thickening and minute digitate Excrencences on the Vocal Cords.*—November, 1865. Dr. C. S. Bishop, formerly the able and very popular Demonstrator of Surgery at the University of Pennsylvania, submitted himself to examination. He had overworked in his position, had had an attack of tubercles in the right lung, from which he had almost recovered. Had contracted a severe cold, with a terrible, harassing cough, which had lasted several months. He was aphonic. He would be suddenly seized, while talking, with severe paroxysms of violent cough, as if there were some extremely annoying foreign body in the throat needing removal.

On laryngoscopy, the epiglottis was found bent at its middle, backwards to a right angle. The lower half was upright, so that the bend was abnormal. On the right side was a loss of substance, broad at the free edge, and narrowing as it penetrated down deep to the base of the epiglottis. It was as if a V-shaped portion had been excised by two cuts with scissors. The spur on the extreme right of the epiglottis thus made and exposed, hung down much like a cur's ear, and was covered with a white-ash colored exudation, broader than that upon the upright portion of the epiglottis. The linguo-epiglottidean frænum was much exposed and enlarged. The arytenoid cartilages were unusually long and thin. The cartilages of Santorini were also very distinct. Through the abnormal fissure of the epiglottis the left superior and inferior cords were seen thickened towards the arytenoid ends. On the arytenoid end of the inferior right cord small, digitated processes of abnormal growth projected inwards.

Remarks.—As suggested by the patient, probably there had been ulcerations upon the laryngeal surface of the epiglottis, which, in healing, contracted and bent the epiglottis, weakened as it was by the loss of substance, which was occasioned by a deeper ulceration wholly through all its tissues.

CASE X.—*Sessile Growth involving the whole of the Right Inferior Cord, and one half of the Left Inferior Cord towards the Thyroid End.*—Miss A. M. J., 28 years of age, born in Jaffrey, N. H., residing in Pepperell, Mass.; school teacher for five years; labors not very excessive, as the character of the school was mixed and continued only

half a year. Always strong and healthy, she dates the beginning of her trouble in September, 1862. Hoarseness was the first symptom; no soreness, no dyspnoea, no dysphagia, no cough. Was hoarse just as much in school as out. At first, the hoarseness occurred particularly in the morning, and disappeared during the day. In the morning again, it seemed as if she had taken a new cold. Could talk with an effort, and could sing until September, 1864. She continued with varied alternations of relief and trouble till the spring of 1865, when her health failed somewhat, and she gave up her school. At no time was she entirely free from the hoarseness, which gradually grew worse, despite active general and local treatment, faithfully and skilfully applied by her attending physician, Dr. Miles Spaulding, of Groton, Mass., and his consultees. In June, she became entirely aphonic. Sept. 14th, 1865, came under the observation of the writer. Condition—perfect, blooming health, except the aphonia.

Laryngoscopy showed the existence of a sessile tumor on the right inferior vocal cord, near its insertion into the thyroid cartilage. At first observation it appeared the size of a split pea, the long axis parallel to that of the cord. Upon subsequent careful and repeated examinations, the patient's throat being extremely difficult to manage, it was found that the growth was much more extensive than was imagined, covering the whole right inferior cord, and involving the thyroid half of the left inferior cord, also sessile. When the glottis is open, it appears of a pale-red color; when it is closed, it seems white and exsanguine. Its surface is irregular. At the thyroid junction of the cords it projects a teat-like process upwards. Towards the arytenoid end of the right cord it presents a head like those mentioned in the cases just related, globular and bossed.

[To be continued.]

TREATMENT OF CHOLERA.

[Communicated for the Boston Medical and Surgical Journal.]

MESSRS. EDITORS,—In the last number of your JOURNAL is an article on cholera and its management and medical treatment, which is good so far as it goes, describing the cause and course of this disease; but when we meet the disease, face to face, in a severe form, as I have often done, with anxious relatives standing around, and a more anxious patient looking to us for a mitigation of their distress, it is not for us to theorize much on the subject, but to go to work immediately with dosing and friction, with strong sinapisms over the entire bowels, and if one remedy is better than another, to employ it at once. There was a time when ignorance was excusable, but that time is in the past. Incontrovertible facts prove that the application of ice, or any other principle of treatment other than that of a stimulating one, is not only hazardous but murderous. By stimu-

lants I do not mean alcoholic, as those are most certain death if the case be a bad one; but pure stimulants, such as capsicum, and others that are nearly so—camphor, xanthoxylum, &c., which are the only reliable ones to use or trust. I have seen cholera in all its forms, and have seen the effect of ice, alcohol, opium, &c., and none of them are to be relied upon. But some content their consciences by saying, I have done as authority recommends, and consequently it is right. But I believe in progress, and if one remedy is better than another that we ought to use it, even if an *old lady has used it first*.

For the benefit of the profession, I will give a formula which in my hands has proved better than any remedy with which I am acquainted:—**R.** Capsici baccati. tr., f $\frac{3}{4}$ iv.; gum. camphoræ, 5 ij.; lobelia inflatæ sem., 5 i.; xanthoxyli fraxinei, 5 viij.; ol. menthae piperitæ, f $\frac{3}{4}$ i.; ol. gaultheriæ, procumb., f $\frac{3}{4}$ i.; ol. cassiaæ, f $\frac{3}{4}$ ss.; sp. vini rect., cong. i. M. Digest ten days, shaking frequently. Dose from one tea to one tablespoonful in sweetened water, warm if convenient; repeat often if it is not retained, and give by enema as well as by the stomach, in warm water. Give also rice coffee made strong; let the rice be well burned, and give the coffee freely. Give also beef-tea, made by broiling the beef slightly, cutting it fine, and covering it with boiling water; let it stand ten minutes, press it out and give it to the patient freely.

After the vomiting and purging are stopped, very little medication is necessary; but control the fever by warm bathing with lye water. Take, also, rhei pulv., menthae piperitæ, potassæ bicarb., of each one spoonful; add one half a cupful of boiling water, sweeten, and give one tablespoonful once in three or four hours. Perfect rest for several days is necessary. The diet should be light and easy of digestion.

S. P. HUBBARD, M.D.

Taunton, Mass., January 20, 1866.

Reports of Medical Societies.

EXTRACTS FROM THE RECORDS OF THE BOSTON SOCIETY FOR MEDICAL IMPROVEMENT. BY FRANCIS MINOT, M.D., SECRETARY.

Nov. 26th.—*New Pulvérisateur*.—Dr. C. G. PAGE showed a *pulvérisateur* designed by him, by means of which the pulverization was made to take place within the mouth, and could be directed to any part of the throat. The special superiority of this instrument is, that caustic and colored fluids can be used without danger of staining the skin of either operator or patient. The instrument consists of two tubes parallel to each other for a distance of three inches or more, the points tapering and approaching each other at a right angle, as in the usual form. The fluid-bearing arm is also bent downwards at a right angle, so as to reach the vessel containing the liquid. The instru-

ment at the same time serves the purpose of a spatula, depressing the tongue sufficiently for all practical purposes while using it.

DEC. 26th.—*Old Pericarditis and general Cardiac Hypertrophy.*—Reported by Dr. J. N. BORLAND. The patient was a man 32 years old, who entered the Boston City Hospital on Dec. 5th, he never having been ill, excepting with rheumatism and its sequelæ. Of this, however, he had a succession of attacks in the acute form, at the ages of 7, 8 and 9 years, and four or five times since. In 1848, and once later, he had pericarditis. Since 1848, he has noticed an irregularity in the heart's action. His last attack of rheumatism was in the spring of 1863. Has had fugitive pains since.

On Nov. 26th, having been exposed to a current of air when heated, his present sickness commenced with pains in his back and shoulders. On the morning of entrance into the hospital, his pains became more general. When first seen, the record states that he had much pain in foot, shoulder, arms and hands, though no great swelling or redness. Thick creamy coat on tongue; poor appetite; costive bowels; high-colored urine; pulse 96, full, strong and regular. He had been under medical advice, and had taken colchicum and morphia.

On Dec. 6th, Dr. Borland saw him for the first time. The heart's action was heavy, labored, most marked at apex. Pulse 40, regular, large, soft and compressible. Face livid. Dulness existed from the fifth rib to the ninth, and laterally from the middle of the sternum to one and a half inches below the left nipple. The sounds of the heart were indistinct, particularly the second, obscured and distant; some apparent aortic regurgitation. **R.** Vini. colch. rad., gtt. x.; liq. ammon. acet., 5i. M. Every four hours. **R.** Ext. hyoscyami, ext. conii, $\frac{1}{2}$ gr. ijs. M. Instead of morphia. **R.** Emplast. epispast. 4×4 inches over heart. Enema of soap suds. Pulse, at 5, P.M., 36.

Dec. 7th.—Pulse 34. Coloring of countenance better, though the lips are still livid. Enema acted freely. No bulging of the intercostal spaces. The pill of hyoscyamus and conium not being sufficient, the patient resumed the use of morphia in the night. The colchicum was omitted, and citrate of magnesia was ordered for a purgative. If morphia was required at night, it was to be given by subcutaneous injection, in dose of quarter of a grain.

Dec. 8th.—Has assumed upright position. Pulse 30, strong wave, heavy cardiac impulse. Lividity of countenance increased. Spasmodic twitchings of face and arms. Is inclined to doze, dropping asleep while answering questions. Thinks amount of urine has diminished within a few days past. Took about eight ounces of sol. citrate of magnesia, without effect. Sounds of heart about as at previous record, excepting the second sound being slightly more distinct. Dulness is somewhat less extensive. May have cream-of-tartar water for drink. **R.** Brandy $\frac{1}{2}$ ss. as needed; and spts. eth. nitrosi, 3i. every three hours. Full enema this afternoon.

Dec. 9th.—Skin moist. Pulse 34. Since yesterday afternoon has taken half an ounce of brandy every two hours. States that he has never been in the habit of using any kind of alcoholic stimulus. Omit brandy and substitute champagne, three ounces every two hours.

Dec. 10th.—Having been taking his stimulants for about thirty-six hours, at about 5 o'clock this A.M. heart began suddenly to beat much faster, the pulse rising to 98. Now, 10, A.M., pulse 100. Tongue

red on edges, creamy on centre, moist. Increased amount of urine in past six hours. The champagne to be given every four hours. **R.** Magnesiae citras sol., 3 vi., and repeat in six hours if no dejection. After opening the bowels, **R.** Potassæ acetatis, potassæ bicarb., 5ss., M., in lemonade every four hours.

Dec. 11th.—Medicine produced one small dejection, removing the slight abdominal soreness and tenderness, of which he had complained. Urine free. Tongue as before. Can lie on back without discomfort. Dulness exists from the fifth to the eighth rib. Impulse less heavy. Apex strikes parietes sharply. No bulging of intercostal spaces. Slight systolic murmur exists, loudest over base. Second sound less sharp than natural. May have lemonade freely. Diet hitherto has consisted chiefly of raw oysters. Asks for, and may have, eggs in addition.

Dec. 12th.—Appears easier. Pulse 100. Tongue moist and cleaning. **R.** Sol. magnes. citratis, q. s. 10, P.M.—The pulse again suddenly fell to 34, the patient complaining of considerable pain in the cardiac region. It soon fell again to 22 per minute, beating for some time at that rate, then rising to 28. He was immediately ordered half an ounce of brandy every hour, with sinapisms to the chest. At 1, A.M., Dr. B. saw him, and found him somewhat anxious, but quiet. Face pale. Extremities bathed in cold sweat. Pulse 28, and very irregular. His brandy was directed to be continued, and given in effervescent soda water; and **R.** Ammoniae carb., gr. v., in syrup, every hour.

Dec. 13th.—Pulse, since 2, A.M., 32, regular. Appears easier, but has some dyspnea. **R.** Spts. ether. co., 3i. p. r. n. Omit brandy and soda, and substitute champagne. At 12.30, P.M., he died.

Autopsy.—The heart, empty of blood, weighed thirty-three ounces, and was in every part greatly hypertrophied. The aortic valves were greatly thickened, with some cretaceous deposits on the inside. The pericardium was in every part universally adherent by tight old adhesions. No marked or old disease of the kidney was discovered, though there was some apparently commencing inflammatory action.

This case attracted considerable interest from the remarkably slow and protracted action of the heart, with its sudden change of rate; and the suggestion of Dr. C. Ellis is perhaps the most satisfactory—that the heart which has been working so heavily and at such a disadvantage for so many years, at last under its new burden breaks down in its action, as a tired horse gives out. Responding to the action of stimulants, it resumes a more natural beat for a while, then again gives out, and this time hopelessly.

DEC. 26th.—*Hydrocephalic Skulls.*—Dr. JACKSON exhibited two fine specimens, which he had received within a few weeks for the Museum of the Massachusetts Medical College.

The first was presented by Dr. B. Joy Jeffries, and was formerly in the collection of his grandfather, the first Dr. Jeffries. It was prepared by Dr. A. Ramsay, a Scotchman, who was here for some years, and had a high reputation as an anatomist. The skull measures in its greatest circumference 27 inches, and over the head, from one auditory meatus to the other, 19 $\frac{1}{4}$ inches.

The other specimen was presented by Mr. Walter C. Blaisdell, a member of the present medical class; and the following facts were

obtained by him, chiefly from the mother, but partly from what he saw of the case during life.

The child, a female, was three years old to within a month at the time of its death, which occurred within the last year, and was occasioned by a slight diarrhoea of a week's duration. The head was about twice the natural size at birth, and the anterior fontanelle very large; the enlargement increasing gradually, so that about a week before death it measured in its greatest circumference $27\frac{1}{2}$ inches. It was never able to sit up and support the head, nor even to turn it from the left side, upon which it always lay. It never spoke, and seemed to have no intelligence. The vision was always very imperfect, and occasionally quite lost; and there was also a slight strabismus from birth. For a time there was slight deafness, but this increased, so that it could only hear when the mother spoke in a very loud tone of voice. It slept generally not more than $1\frac{1}{2}$ in 24 hours; and was very restless, moaning much of the time, as from distress, and requiring a free use of opiates, but not crying out as from sharp pain. Never convulsed. Faeces generally passed involuntarily, and sometimes the urine. In regard to its general health, it was feeble, thin and pale, but sufficiently warm; nursed its mother heartily until the time of its death, and took cow's milk, but never any solid food.

On examination, which Mr. B. made alone, he found the cranial cavities filled with serum, and the cerebellum sufficiently natural in appearance; but of the cerebrum he found very little remains.

The specimen, which is an uncommonly fine one, and was very beautifully prepared by Mr. Blaisdell, shows all the characteristics of a hydrocephalic skull—the great disproportion between the facial portion and the vault of the cranium—the thinness of this last and the great deficiency of bone in place of the anterior fontanelle—the disappearance of the supra-orbital ridge—the numerous Wormian bones, one of which is of large size—and the deeply serrated sutures. The greatest circumference is 27 inches; and from one auditory meatus to the other, over the top of the head, and allowing for the deficiency at the anterior fontanelle, it measures 20 inches.

Bibliographical Notices.

Eléments de Pathologie Interne et de Thérapeutique (Principles of Internal Pathology and of Therapeutics). Par Prof. NIEMEYER. Traduction de l'Allemand, par Drs. CULMANN et SENGEL. Tom. 1er. Paris : Juillet, [1865].

[Read before the Norfolk (Mass.) District Medical Society, Jan. 10th, 1866, by F. MINOT WELD, M.D., of Jamaica Plain.]

This is an octavo of nearly nine hundred pages, and is peculiarly interesting as showing that the medical world of Europe is progressing in the same direction as our own.

The author treats organic diseases before constitutional ones, on the ground that the latter generally lead to the former, and in consequence are better understood if the former are first studied.

First, then, we have "Diseases of the Organs of Respiration,"

beginning with those of the larynx, at the head of which stands "Hyperæmia and Catarrh of the mucous membrane." This disease has sixteen pages allotted to it, including separate sections on Pathogeny and Etiology, Pathological Anatomy, Symptoms and Course, Diagnosis, Prognosis, Treatment. Then follow chapters on Ulcerations of the Larynx in the infectious diseases, Tuberculous Ulcers, Cancer of the Larynx, Ædema of the Glottis, Laryngitic Perichondritis, Neuroses of the Larynx, and Spasm of the Glottis, this list covering fifty-five pages, and giving a fair idea of the care and minuteness evinced throughout the work.

Under "Croup" is an interesting note by the reviser, Dr. Cornil, on the respective German and French meanings of the words diphtheria and croup. In France, diphtheria means a constitutional disease, non-inoculable, but contagious, specific, and liable to appear on the mucous membrane of the respiratory and digestive passages, the vulva, prepuce, conjunctiva and skin. Croup is applied only to the localization of diphtheria in the larynx. In Germany, on the contrary, croup denotes the production on a mucous membrane, of a fibrinous exudation. So acute pneumonia, the type of inflammations with a fibrinous exudation, is called croupal pneumonia in all their works on pathology. Diphtheria is applied to those cases in which the exudation is developed not only on the surface, but also in the substance of the mucous membrane. This difference is attributed to the fact that the Germans class croup and pneumonia together, on account of the anatomical identity of the exudations in the two diseases. But the French distinguish, having reference to the etiology, the former being due to contagion or epidemic, and the latter to cold, and ranking croup as a constitutional disease and pneumonia as a local inflammation.

Passing over Diseases of the Trachea and Bronchi, we come to those of the Pulmonary parenchyma—to which the author gives one hundred and fifty pages, forty of which are devoted to Pneumonia.

Inflammations of the Lungs, he says, are most naturally divided into three forms, viz. :

First : Croupal Pneumonia, which represents the same condition in the pulmonary cells that croup does in the laryngeal mucous membrane, i. e. fibrinous exudation.

Second : Catarrhal Pneumonia, where we have the same essential conditions as in laryngitis and bronchial catarrh, i. e. an increase of secretion and an abundant formation of fresh cellules, without coaguble exudation in the cells.

These two forms of inflammation deposit their exudations on the free surface without the pulmonary tissue itself suffering any essential troubles of nutrition.

The third form, Interstitial Pneumonia, on the contrary, consists of an inflammation which attacks the pulmonary cell-walls and the connective tissue between the lobules. This last form is almost always a chronic affection and is generally called chronic pneumonia, in opposition to the other two, which are acute.

As to the treatment of pneumonia I quote the author's words, at intervals. "Left to itself, it almost always terminates in recovery, provided the patient is robust, and the disease not complicated nor excessively intense. This fact is of recent discovery, and it is to the

expectant school of Vienna, and to the success of the homœopaths, that we owe this important knowledge. From it we deduce the rule that pneumonia demands therapeutic intervention as little as variola, rubeola, and other self-limited diseases, when they attack persons previously in good health, are not complicated, and are of an average intensity. It is even proved that interference has an injurious influence on the course of the disease. This is especially true of bleeding. If a person dear to me were affected with pneumonia, I would much rather see him in the hands of a homœopath, than in those of a physician who believed that he held the cure of the disease at the point of his lancet; however great may be the value I attach to bleeding when it is reserved in the course of pneumonia for certain emergencies. The experiments of Dietl prove that bleeding is not a specific against pneumonia, and that it does not cut short the course of the disease.

"I have made extensive applications of cold with most favorable results. I always have the chest on the affected side covered with napkins wrung out in cold water. These should be renewed every five minutes. The patient almost always expresses relief in a few hours. The dyspnœa and often the frequency of the pulse is lessened, and sometimes the temperature is reduced a degree. Very rarely it fails to produce relief, and the patient refuses to continue the application on account of its inconvenience. Bleeding should be employed only in the three following cases. First, when the pneumonia has just attacked a person healthy and robust heretofore, and the temperature exceeds 40° Centigrade (122° Fahrenheit), and the pulse is above one hundred and twenty. Secondly, when a collateral oedema in the section of the lungs spared by the pneumonia threatens life. Thirdly, in symptoms of cerebral congestion.

"Digitalis is indicated when the pulse is between one hundred and one hundred and twenty, often in combination with neutral salts. Tartar emetic has lately sunk into discredit. Ipecac, quinine, veratrine, and inhalations of chloroform have not given results satisfactory enough to merit employment in private practice.

"In the latter stages stimulants are to be freely used, and in a slow convalescence, quinine and iron, &c. are beneficial." We see that veratrum viride, so justly popular in this vicinity, is scarcely mentioned by Prof. Niemeyer, while the time-honored blisters and sinapisms are entirely ignored. He sums up: "In most cases of pneumonia the remedies indicated are all that will be needed, and a harmless mixture, or a palatable drink, which, given every two hours, will tranquillize the patient, is sufficient to lead the disease to a speedy and happy termination."

Further extracts are unnecessary to show the author's views.—In a word, the general course of treatment he recommends approximates closely in character to that of the advance of the expectant school of this vicinity, though he has evidently not quite reached the conclusion that "Disease is a part of the Plan of Creation."

In Kings County (N. Y.) Hospital, there were remaining July 31, 1864, 326 patients; 3,117 were admitted during the year, to July 31, 1865, making the whole number under treatment 3,443, or 842 more than the previous year; 336 died, and 370 remained at the end of the year.

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

BOSTON: THURSDAY, FEBRUARY 1, 1866.

COMMUNICABILITY OF CHOLERA.—QUARANTINE.—NECESSITY OF CONGRESSIONAL ACTION.

At a meeting of the Commissioners of Health of New York city, held Jan. 23d, the Resident Physician, Dr. Sayre, announced that "information had been obtained by the last arrival from Gaudaloupe, that the cholera was introduced there by a trunk containing clothing of two persons who had died of the disease while on passage from Marseilles, where the disease prevailed; and the fact that the woman who washed the clothes, and all her family, died almost immediately; and that a number of persons attracted to her house by the sudden mortality were also attacked, many of whom died." He also read a letter from Dr. C. A. Lee, Professor of Hygiene in the Buffalo Medical University, which we give as a fair representation of the views concerning the communicableness of cholera now almost universally adopted by the profession in Europe, and which we are convinced will be largely endorsed by physicians in this country also, when the facts upon which they are based are fully understood.

"Lewis A. Sayre, M.D.

" BUFFALO UNIVERSITY, MEDICAL DEPARTMENT, }
January 17, 1866. }

"DEAR SIR,—Some time since you did me the honor of requesting my opinion in regard to the contagiousness of cholera. Circumstances beyond my control have prevented attention to your request, and even now I can only briefly indicate the conclusions at which I have arrived, after close and varied personal observations of its progress, both in our own and in foreign countries.

"In the first place, then, I have seen no reason to believe that the disease is ever communicated directly from one person to another, even under circumstances of the greatest intimacy. In other words, *it is not contagious*, according to the common understanding of that word.

"On the other hand, facts abundantly prove that *the disease is portable*, and always follows the great routes of travel and commercial intercourse. I hold, also, that we have satisfactory evidence that the disease is communicated through the evacuations of those infected with it, and in this way only. I could adduce many instances where there can be no question that the cholera has been conveyed to hitherto healthy localities by means of one infected person, in whom the disease has manifested itself only by an apparently trifling diarrhoea. Persons so affected may doubtless travel from one place to another, without serious development of the disease, and leave behind in privies and water-closets germs which may give rise to a deadly epidemic. It is this fact, so generally overlooked, or not recognized, that has thrown so much mystery over the causes and mode of extension of this most fatal and mysterious malady.

"This fact also explains those apparent anomalies in the progress

of the disease, why it often takes no defined course in its wanderings, but spreads indifferently in different directions and to different quarters, now with the wind and now against it—now following the main routes of travel, nevertheless often deviating from them, *but travelling no faster in any case than ships, railroad cars, and men travel*. Those great leaps which it sometimes seems to take, and which have been supposed to be owing to the poison of the cholera being carried by winds, are thus satisfactorily explained.

"Although cholera is undoubtedly communicated by the fresh dejections of those infected, I think there can be little doubt that, if the poison may not be actually present in the stools just discharged, it may be generated in them at a later period under certain conditions favorable to its development. These conditions are now pretty well understood. The contact of such discharges with putrid animal and vegetable matters is very certain to develop the poison of cholera, and an impure atmosphere from the presence of similar matters favors its rapid dissemination. The accumulation of filth and organic remains, imperfect sewerage, overcrowding of tenement houses, and the saturation of the earth with the products of decay, are the chief causes of the greater intensity and diffusion of the disease in large cities than in other localities. To these, however, may be added the great imprudence with which cholera discharges are emptied into common privies, gutters and sewers, which serve as *foci* from which the malady spreads in every direction. Hence, we find that in localities visited by the disease, the houses and streets in which those infected reside are the places of the greatest danger. But while these are being depopulated, the epidemic spreads rapidly; attacking first those low, filthy, over-crowded places, where the predisposing and favoring causes most abound; afterwards ravaging portions of a city and localities which were at first wholly exempt, and which were probably deemed safe from any danger of an attack.

"I think the experience on board the Atlanta tends strongly to confirm the correctness of these views. The disease originated in the steerage, where it may have been brought by one individual laboring under *cholerine*. As the water-closets used by the steerage passengers were not used by the first-cabin passengers or the crew, not one of these latter were attacked by the disease, while large numbers of the steerage passengers, who exclusively used them, were seized with the malady. Does not this theory also afford a good explanation of the fact that the disorder is generally more active on lines of travel by water than by land? Although these views seem to me to be abundantly sustained by well-known and acknowledged facts, I am ready to admit that there are some phenomena which cholera exhibits in its wanderings, which it is difficult to explain by any existing theory. But this ought not to prevent us from profiting from what is actually known.

"The practical lessons which flow from these considerations are the following:—

"1. Quarantine regulations cannot be too strict nor too rigidly enforced.

"2. The most thorough sanitary measures must be enforced and carried out in all places exposed to the invasion of the disease; especially in large cities, where every effort should be used to have all

houses, streets, alleys, privies, drains, cess-pools, &c., thoroughly cleansed and disinfected.

"3. All intercourse with places infected with the disease must be absolutely prohibited, or at any rate guarded with the greatest care and precaution.

"4. Should the disease unfortunately be introduced into a place, *cholera stools should never be emptied into necessaries and water-closets in common use.*

"5. The police should be instructed to pour into every privy and water-closet suitable disinfectants, or furnish the same for this purpose."

If any evidence were wanting as to the hasty and ill-advised character of the resolution concerning cholera adopted by the Suffolk District Medical Society a few weeks ago, a resolution which we felt authorized to state at the time in no way represented the opinion of the medical profession of Boston, and which has since been generally condemned by the medical press of the country, it may be found in the use which has been made of it by a class of persons in this community for wholly selfish purposes. It will certainly be a surprise to many to learn for the first time, by way of Philadelphia and New York, that we in Boston are in favor of the abolition of quarantine, and unless the Society feels justified, after a careful consideration of the present epidemic, in recommending a course so entirely at variance with the action of similar bodies elsewhere, it is its duty to express itself in a way capable of no such misuse in future. An article on this subject in the Philadelphia *Medical and Surgical Reporter* will be read with interest.

"In anticipation of, and with a view to influence or counteract probable congressional legislation on this subject, the *free-traders* and *free-intercourse* people—that is, the importers and merchants—of Boston have already issued a pamphlet, addressed to the same class of citizens of New York, in which the abolition of quarantine is advocated. We are sorry to see that the resolutions passed by the Boston physicians, on the abstract question of the contagiousness of cholera, are now used by these men as an argument in favor of abolishing quarantine. If that was the object of these resolutions, which we have quoted in a previous number of the *Reporter*, then we cannot too severely condemn the Suffolk District Medical Society for its hasty and injudicious action, which furnishes to these merchants, whose only care is for their bales of silk and boxes of dry goods, and eventually for their dollars and cents, a strong lever, by which they hope to lift quarantine out of its foundations, and throw it into the sea. And we are also sorry to see that Dr. Snow's otherwise excellent paper—which unfortunately was addressed to the public at large, who have no means of judging correctly in such cases, instead of to the profession—is in the same way used to make capital for the importers and jobbers. * * * * * The profession, when it passes resolutions which are calculated to go before the public, is *responsible* for their interpretation, and the uses to which they are put by designing men for purposes of their own. Is the Suffolk District Medical Society willing to let its official seal be affixed to the pamphlets of the Boston merchants, by furnishing them with ambiguous resolutions to be

used *ad libitum*, and for purposes detrimental to the public welfare ? If not, we call upon it to remedy the bad effects resulting from an injudiciously taken step. It is not too late for that society to put itself right before the public and the profession, and we beg them to take the matter into early and earnest reconsideration."

There can be no question, it seems to us, as to the necessity of some immediate and general action on the subject of quarantine by the government at Washington, for the folly of independent State or municipal laws in such a country as ours is self-evident. Let the subject receive the consideration of one general scientific commission, which shall calmly investigate the facts observed in the present and past epidemics, and act independently of all such incompetent and meddling powers as that above referred to. We commend to the notice of our readers the judicious argument of Dr. Sayre in his recent report to the Board of Health on this subject. He says :—

" New York is accessible by the land as well as by the sea, and unless these same quarantine regulations are enforced in every seaport town upon the entire coast, there is no security ; but the disease being imported into some of these seaport towns, may come to us by railway communication. We may therefore see the necessity for Congress or the General Government to take possession of this matter, and enforce a uniformity of quarantine regulations at every port of entry. The Government establishes a port of entry, collects revenue at a port of entry, and should, therefore, perform the duties connected with a port of entry, one of which is a proper quarantine establishment, and kept under military regulation, by which it may be rendered uniform and efficient. It sometimes happens that the port of entry, as in our own city, lies upon a river bordering upon two States, and the port may be in one State, and the most advantageous place for a quarantine under the jurisdiction of another. This conflict of jurisdiction renders it essential that it should be placed under the control of the General Government. The General Government would not hesitate to take possession of any place where it could best protect the country from an invasion by a foreign foe, irrespective of State boundaries, or State jurisdiction, were it to come in the form of armies or fleets. How much more necessary, then, that the same precautions should be taken against a secret foe of pestilence and poison, vastly more destructive of human life than a fleet equipped with Armstrong guns. As there are also many ports of entry, it is a necessity that the General Government should assume this control, in order that their action should be uniform ; as we have already received an official communication from the city of Boston, in which a committee of medical men have stated 'that the disease is neither infectious nor contagious ; cannot be communicated by one person to another by their effects or things, their excretions or secretions, and that it is an epidemic entirely beyond quarantine regulations, or military cordons, and they, therefore, unanimously recommend the immediate removal of all such restrictions.'

" Boston being a port of entry, and having promulgated in pamphlet form to the merchants of this city their views upon this subject, may introduce into their harbor commercial intercourse, and the disease be disseminated throughout the country by railway communica-

tion; it is, therefore, patent that it is a necessity that the General Government should assume jurisdiction in this matter, as the General Government is responsible for the protection of the entire nation, and, by convention with Canada and the British provinces, a uniformity of quarantine could be established upon the entire coast, and thus the continent be protected from this terrible scourge.

"Congress has recently very wisely enacted a law to prevent importation of disease among our cattle. How much more necessary that it should enact a law which would enable us to prevent this plague and others from being imported among our people?"

Injection of Animals with Fluids from Cholera Patients; Death with Cholera Symptoms. Efficacy of Subcutaneous Injections in the Treatment of the Vomiting of Cholera.—At the meeting of the *Société Medicale des Hôpitaux*, at Paris, held November 22d, M. Hérad reported the case of a young girl affected with cholera for two weeks, who continued to vomit daily about two quarts of a liquid transparent as water and but slightly differing from that fluid in composition. Of this liquid M. Robin injected a quantity into the trachea of healthy dogs, producing vomiting, liquid evacuations and chills—in short, symptoms strictly analogous to those of cholera, and terminating in the more or less speedy death of the animals. The same result followed injection with the liquid portion of the blood drawn from cholera patients during the period of reaction. Injected into the stomach, these symptoms did not follow, a circumstance probably due, according to M. Robin, to the fact that the liquids were digested, and thus lost their toxic properties. In one case, however, a dog which had by chance devoured a large quantity of the alvine dejections of a cholera patient, died with all the symptoms mentioned above. In this case it was supposed that the stomach was unable to digest the whole of the morbid excretion, and the remainder was absorbed with all its deleterious properties, as in the case of injections into the trachea.

M. Buequoy stated that M. Bourdon had often stopped, by means of subcutaneous injections of morphia, the vomiting of cholera patients, after it had resisted all other methods which had been tried.

At the meeting of the Imperial Academy of Medicine, held on the 2d ult., M. Guerin presented a note from M. Pélican, the Director-General of the public Health in Russia, in which he remarked that Russian physicians, who were all anti-contagionists in 1831, are now completely converted to the doctrine of the contagiousness of cholera.

At the last accounts the cholera was raging at Martinique, and two cases had arrived at Havana on board a steamer from Europe; the authorities placed her in quarantine.

The deaths from cholera in Paris during the present epidemic had reached the number of 6,337 on the 22d of December last.

OBITUARY.

DR. THOMAS W. BLATCHFORD, of Troy, N. Y., whose death was recorded in the JOURNAL last week, was born in England in 1794. He was quite young when he came to this country, and resided with his parents at Bridgeport, Conn., until the year 1800, when the family went to Lansingburgh to reside. After a thorough course of scholarly training in this country, he attended the lectures of Sir Astley Cooper in London. He went to Troy in

1828, and was a practising physician there for about forty years, being at the head of his profession. He was justly esteemed as one of the most eminent physicians in the State. He has during his long professional career contributed numerous monographs to the standard medical publications of the country. One on Hydrophobia, published some years since, attracted general attention in this country, and was translated into several continental European languages and published extensively abroad. He had a thorough medical education, and was an extensive reader in the line of his profession. He held prominent positions in the National and State Medical Societies, as well as in other local and general medical associations. Aside from medical services, Troy owes him a lasting debt of gratitude for his noble exertions in the cause of education. He was member of the first Board of Education in 1849, and continued an active member until 1856, when the cares of his profession and advancing years induced his resignation. He manifested great interest at all times in the religious and moral questions of the day—was an earnest advocate of temperance—and for a number of years an elder in Dr. Kennedy's church, at which he was a regular attendant. Possessed of the noblest qualities of head and heart, with talents of the highest order, a mind inspired by the noblest impulses, his death will be mourned as a public loss, no less than an irreparable private grief to the immediate circle of relatives and friends who best knew his manly and noble characteristics.

DR. HENRY BIGELOW, who died on the 21st of January at his house in Newton, was a native of Worcester, was early fitted for college, and graduated at Harvard College in the class of 1836. After entering upon his profession in 1839, he practised for a short time in the town of Buxton, in Maine, but soon settled in Newton, where he resided till his death. It is seldom our duty to record the decease of a person more worthy, beloved and useful, and who will be more generally and sincerely lamented. He had resided in Newton for twenty years, covering the period of its growth and prosperity, had always been identified with all its interests, and for the last eighteen years has stood at the head of its educational affairs. To his peculiar ability and good management is the town indebted for the noble condition of its public schools. In his profession Dr. Bigelow was skilful, faithful and kind. He never attended a patient who was not improved morally by his presence. His gentle spirit was in sympathy with all their sufferings, and his pure Christian faith seemed to light the way of the dying through the dark vale of the shadow of death. He was a very prominent member of the Channing Church at Newton Corner, and it may be long before the great vacancy his removal has made will be filled.

New Medical Journals.—We have received the first number of the *Savannah Journal of Medicine*, edited by Juriah Harris, M.D., Professor of Physiology in Savannah Medical College, J. B. Read, M.D., Professor of Materia Medica, do., and J. G. Thomas, M.D., It will appear bi-monthly.—The *Cincinnati Journal of Medicine*, edited by George C. Blackman, M.D., Theophilus Parvin, M.D., and Robert Bartholow, M.D. It is to be published monthly.—The *Atlanta Medical and Surgical Journal*, edited by J. G. and W. F. Westmoreland, M.D.—Also prospectuses of the *Detroit Review of Medicine and Pharmacy*, a monthly journal, to be edited by George P. Andrews, M.D., Samuel P. Duffield, Ph.D., and Edward W. Jenks, M.D.; and the *Medical Record*, to be published twice a month by Wm. Wood & Co., New York. Editor, George F. Shraday, M.D.

VITAL STATISTICS OF BOSTON.
FOR THE WEEK ENDING SATURDAY, JANUARY 27th, 1866.
DEATHS.

	Males.	Females.	Total.
Deaths during the week	40	37	77
Ave. mortality of corresponding weeks for ten years, 1856—1866	39.7	35.9	75.6
Average corrected to increased population	00	00	82.36
Death of persons above 90	3	3	3

CORRECTION.—We learn from Surgeon-General Dale that the name of Br. Lt.-Col. Bowman B. Breed, late U. S. Vols., was accidentally omitted from the Roster of Massachusetts Surgeons, on the second page of his Report.

DEATHS IN BOSTON for the week ending Saturday noon, January 27th, 77. Males, 40—Females 37. Abscess, 1—apoplexy, 3—disease of the brain, 1—bronchitis, 1—burns, 1—cancer, 1—consumption, 20—convulsions, 1—croup, 1—diarrhoea, 2—diphtheria, 2—dropsy, 3—dropsy of the brain, 1—epilepsy, 1—remittent fever, 1—scarlet fever, 1—typhoid fever, 2—disease of the heart, 2—hip disease, 1—infantile disease, 2—influenza, 1—disease of the liver, 2—congestion of the lungs, 1—inflammation of the lungs, 6—necrosis, 1—old age, 5—paralysis; 1—premature birth, 1—puerperal disease, 1—pyæmæla, 1—smallpox, 1—spina bifida, 2—teething, 1—unknown, 4—disease of the windpipe, 1.

Under 5 years of age, 18—between 5 and 20 years, 13—between 20 and 40 years, 19—between 40 and 60 years, 9—above 60 years, 18. Born in the United States, 56—Ireland, 18—other places, 3.